INFANT SUPPORT SERVICES PLAN OF CARE

Infant Name:	Date of Birth	Birth Weight	Birth Ht/Length	Gestational Age	Medical Care Provider:
Caregiver Name:					
Care Coordinator:					Discipline

PROBLEMS/NEEDS	GOALS/OBJECTIVES	INTERVENTIONS
Health:		
Family Planning:	Assist family to achieve their goal of spacing and composition of family through use of birth control method of their choice.	
Smoking: ☐ Caregiver Amount ____ ☐ Quit Smoking When ____ ☐ Environmental Smoke Who ____ ☐ Smoke-Free Environment	Infant will have a smoke-free environment.	
Immunization Status of Caregiver (Based on Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date Status of Preschool Child(ren) (Based on MICR/Immunization Record/MCP) ☐ Up To Date ☐ Not Up To Date	Infant will remain current with immunizations.	
Nutrition:		

Infant Name: _____

INFANT SUPPORT SERVICES PLAN OF CARE

PROBLEMS/NEEDS	GOALS/OBJECTIVES	INTERVENTIONS
Emotional/Mental Health		
Environmental:		
Parenting Class:	Caregiver will receive the benefits of a group setting.	
Transportation:	Infant will not miss any appointments due to a lack of transportation	
Other:		

We the undersigned have reviewed the initial assessment and have participated in the above described plan. We concur with the number of visits to implement the interventions.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature Date SW Signature Date RD Signature Date

Care Plan Update

We the undersigned have reviewed the care plan update and agreed to the changes in the above described plan. We concur with the number of visits to achieve the specific objectives.
Estimated Number of Visits By: _____RN _____SW _____RD

RN Signature Date SW Signature Date RD Signature Date